favorable. On multiple occasions (as literature well documents) we have seen a dramatic rise in the systolic blood pressure within moments after the inflation of this suit. While this must not preclude definitive operation, it does in many cases remove patients from shock and maintain them while they are being prepared for laparotomy, thereby avoiding many of the sequelae of the shock state. The use of the MAST can have a net negative effect unless several potential problems are borne in mind. Its use precludes intravenous infusion via the lower extremities and thus necessitates several upper extremity lines; its use markedly elevates the diaphragms, and closed tube thoracostomy must be performed through a higher intercostal space and with much greater care; and perhaps the greatest risk is an unfounded feeling of confidence by the physician resulting in delays in definitive management and underestimation of volume requirements.

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Dr. Trunkey Replies

TO THE EDITOR: I very much appreciated reading Dr. Jergen's letter. The first point, about the awareness of the cervical spinal cord injury, is an excellent one. In fact, in every patient who is in this category at San Francisco General Hospital a lateral cervical spine film is taken before the patient is moved on to the emergency-trauma table. An exception to this is when a patient comes in with cardiac arrest. In that instance, the anesthesiologist usually maintains the patient's head in an axial alignment and moves right along with the intubation.

In regard to the second point, on the use of Medical Anti-Shock Trousers (MAST), I am also in full agreement. We have previously commented on the use of this device in an earlier Trauma Rounds (Lim RC: Abdominal vascular injuries [Trauma Rounds]. West J Med 123:321-324, Oct 1975).

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Pseudoacetylcholine

TO THE EDITOR: Dr. Morris Vilkin's letter to the editor in the July issue is entitled "Grip Test for Pseudoacetylcholine" and discusses patients with "high titre of pseudoacetylcholine." This is physiological nonsense and I am surprised that the editors allowed it to be printed without correction.

There is, of course, no such thing as pseudoacetylcholine. The abnormal sensitivity to succinylcholine found in some patients is due to a genetic deficiency in the plasma cholinesterase enzyme also known as pseudocholinesterase. The "pseudo" prefix is used because it is not the same enzyme as the cholinesterase which is present in nervous tissue and erythrocytes and which is highly specific in its action, the hydrolysis of acetylcholine.

Pseudocholinesterase on the other hand, promotes the hydrolysis of several choline esters including succinylcholine. In its absence, therefore, the action of succinylcholine is greatly prolonged with the resultant syndrome of persisting weakness of respiratory and other muscles.

Dr. Vilkin's grip test may be a valid screening technique for plasma cholinesterase deficiency. But to allow expressions such as "high titre of pseudoacetylcholine" to appear in print in the pages of a scientific journal can only promote confusion and misunderstanding about a subject of considerable importance.

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Health Care Costs

TO THE EDITOR: I usually find the editorials in the WESTERN JOURNAL astute and throught-provoking, but two that appeared in the June 1977 issue had some serious lapses.

In the first editorial, "Health Care Costs—A Call for AMA Leadership," it is stated "In the not too distant future the rising costs of the nation's health enterprise will equal or exceed the portion of the gross national product (GNP) that can be available for this purpose. In the opinion of some responsible persons this will happen when health-related costs reach approximately 9 per-

cent of the GNP." Who says this is all we can afford and on what data is this based? As long as we continue to spend more money on alcohol and cigarettes than on physicians' services, there seems to be a little more leeway for spending on health. I am not saying that there is not a lot of "unnecessary" expenditure currently in the medical field, but setting an arbitrary limit is silly. An individual should be able to decide for himself how much of his budget he wants to devote to his health (or vices, or rent or whatever he chooses). The problem comes with people who have no money and so the government pays their bill; that is, taxpayers must pay for the care of the indigent before they can make decisions as to their personal budgets.

This leads to a second error: "Unless something is done quickly in the private sector the government will soon have no alternative to imposing a crude and even brutal cap on the money spent." No alternative? Is the author serious? Does he forget that the government makes its own rules? It can make all kinds of alternatives. A few examples might be the following: shift funds from tobacco price supports to public health education, eliminate the terribly cost ineffective Veterans Administration and Indian Health programs and buy all the recipients private health insurance, or eliminate Medicare or Medicaid, or both (that is, reduce the medical care of those groups for whose care it promised to pay, instead of reducing the care of everyone).

The AMA should provide leadership, all right, but a large part of its effort should be education of the public and government, as well as the leadership of organized medicine. This may eliminate the use of the term "inflation rate for health and medical care" (such as used in the editorial "The Federal Trade Commission and Health") when "cost increase" is what is actually meant. Most of the increased cost is for additional or improved services and that's not inflation.

Overall the two editorials were good, but these lapses indicate that maybe the author has been talking to the bureaucrats so long that he is beginning to think like them. Raise your guard.

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Laetrile

TO THE EDITOR: I commend you on the timely article on Laetrile in the July issue [Lewis, JP: Laetrile (Informed Opinion). West J Med 127: 55-62, Jul 1977]. Unfortunately our public is bombarded by quacksters promoting fad diets, vitamin regimens, medications, etc. Since all of these things are garbage, information on them is not to be found in our leading medical journals.

The physician is left to sort through newspaper articles, *Time* magazine, etc. to formulate an opinion. Recently I was discussing Laetrile with an attorney. Although in my own mind, I had reason to believe that Laetrile was worthless, I had no good scientific reference to back up my statement. He will now receive a copy of your article on his desk.

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